

# HOME HEALTH EMERGENCY PREPAREDNESS

*A Handbook to Assist Home Health Care  
Providers in Emergency Preparedness  
Planning*



## *HOME HEALTH EMERGENCY PREPAREDNESS*

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## Table of Contents

<b>Chapter 1- Introduction and Overview</b> .....	1
<b>Chapter 2- Michigan Emergency Preparedness Background</b> .....	4
<b>Chapter 3- Elements of Planning</b> .....	6
<b>Chapter 4- Step1: How Prepared is the Agency?</b> .....	9
Hazard Analysis Worksheet .....	9
Hazard Vulnerability Planning Priorities .....	12
Agency Preparedness Assessment and Planning Checklist .....	13
<b>Chapter 5- Step 2: Develop the Agency's Plan</b> .....	20
Business Continuity .....	23
Communication .....	24
Community Partnerships .....	25
Demobilizing the Response .....	26
Education .....	26
Evacuation and Mandatory Evacuation .....	28
Immunizations .....	29
Infection Prevention and Control .....	29
Isolation and Quarantine .....	30
Memorandums of Understanding .....	30
Mental Health .....	31
Pediatric Patients.....	31
Resource Management .....	32
Safety and Security .....	32
Sheltering .....	32
Surge Plan .....	35
Transportation Plan .....	35
Waivers .....	36
<b>Chapter 6- Step 3: Test and Evaluate the Agency's Plan</b> .....	38
After Action Report and Improvement Plan .....	39
Additional Resources .....	41
<b>Appendices</b> .....	42
A: Sample Emergency Preparedness Policy Language .....	42
B: NY Department of Health's Home Care/Hospice Preparedness Guidelines .....	52
C: Agency Emergency Contact List .....	55
D: Staff Call Down List .....	56
E: Patient Emergency Plan.....	57
F: FEMA Evacuation Guidelines .....	62
G: After-Action Report/Improvement Plan Template .....	63

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# Chapter 1

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## ***Introduction and Overview***

The purpose of this handbook is to assist Michigan home care agencies in writing, augmenting, and evaluating their emergency preparedness plans.

An emergency plan, in the most basic sense, is a guiding document that outlines in detail the systems and protocols which an organization has in place to: ensure the safety of staff and patients, operate within the larger emergency management system, and maintain continuity of services to patients during and after an emergency. The protocols outlined in this handbook are best practices recommended through consultation with providers working in the home care field.

The type of emergencies covered by an emergency plan could include natural incidents like flooding, hurricanes, or winter weather conditions; infectious disease outbreaks; man-made disasters or accidents which cause widespread exposure or dangerous conditions; and others outlined further in this handbook.

For home care providers, like all health services organizations, preparedness is a critical part of the operation for ensuring patient care and safety, staff security, continuity of business operations and its reputation. While at this time, Centers for Medicare & Medicaid Services (CMS) proposes ([484.22 Condition of participation: Emergency preparedness](#)) a basic framework and guideline structure for emergency planning, the most effective preparedness and response plans are comprehensive, agency-wide initiatives that provide explicit protocols requiring all organizational staff and departments to work together under a shared understanding and collaborative effort.

### *Format*

This handbook has several sections, including background on the Bureau of EMS, Trauma and Preparedness (BETP) role in emergency preparedness, a section to assist providers in assessing the strength of their preparedness plans, an in-depth look at various protocol areas that should be considered in plan development, and tools for ongoing evaluation of a plan's effectiveness. The four basic sections are as follows:

- Mission of BETP- To provide information on the basic core framework for medical and public health emergency planning in the State of Michigan. In addition to proposed CMS regulations, together with best practices developed from providers in the field; make for the elements of a comprehensive emergency plan directing an organization's response and post-incident activities to ensure safety, continuity of care, and continuity of business operation.
- Step 1: Hazard Vulnerability or Risk Assessment. Preparedness assessment is the process of determining the various risks and threats an agency and patients might face. It involves estimating the impact of both historical and potential incidents on the business and clinical operations.

- **Step 2: Plan Development.** This is the most in-depth and extensive section of the handbook, outlining the various factors that an agency should take into consideration as it develops or improves its emergency plan. This section of the handbook is divided into a series of topical themes that include such important planning elements as business continuity, surge capacity policies, expectations during an evacuation order, sheltering information, community partnerships, infection control and more. Agencies should read this section carefully and then use the draft policies, available in [Appendix A](#) of this handbook, for model protocol language for use in addressing these topics within the agency's emergency plan. Planning templates are available in the [appendices section](#).
- **Step 3: Plan Evaluation.** Routine evaluation is a critical part of making sure the agency's plan reflects its ability to safely and effectively respond to and recover from a disaster. This section provides information and tools to assist providers in plan evaluation, including protocols for "paper" review and making updates to the emergency plan, drills, and use of after-action reports (AARs).

In addition to these core elements of the handbook, a series of appendices are available at the end of this handbook. Other emergency planning information is available on the BETP [website](#). Visit the Home Health Disaster Planning Resources page in the Partner Resource Section for more information, planning tips, educational programs, and more.

## *Introduction*

Emergency preparedness in medical and health is the capability of public health and health care systems, communities, and individuals to prevent, mitigate, protect against, quickly respond to, and recover from health emergencies, particularly those whose scale, timing, or unpredictability threatens to overwhelm routine health services.

As providers, agency members are well aware of the unique role that home care plays in response to emergency incidents: a role that reflects the unique niche within the health care system as a whole.

This handbook will help establish protocols for meeting the needs of patients while maintaining continuity of operations through a coordinated and continuous process of planning and implementation that relies on measuring performance and taking corrective action.

All disasters begin "locally," and it is important to remember that the response to an emergency can affect not just the agency, but also an entire community. Emergencies of any size can involve numerous medical and public health entities, including health care provider systems, public health departments, emergency medical services, medical laboratories, individual health practitioners, medical support services and transportation authorities.

This toolkit will outline the critical steps the home care agency should take in creating, evaluating and updating its emergency plan. This plan should establish the role of the agency within the structure of emergency response, providing clear instructions and best practices for how each level of staff prepares for and activates in response to an emergency. This includes integration into the community emergency management plan.

The CMS has proposed that – and, in many cases, to maintain accreditation – agencies are

required to have an emergency plan in place. Beyond compliance with these regulations, there are many other very compelling reasons to maintain an emergency plan that is as comprehensive as possible. These reasons include:

- Ensuring the safety and well-being of patients and staff;
- Maintaining continuity of care to patients;
- Ensuring agency financial viability and continuity of business operations;
- Providing agency legal protection;
- Ensuring appropriate utilization of resources; and
- Supporting community and community partners during a disaster.

Home care agencies should plan for emergencies of all types (what is known as “all-hazards” planning). As part of that planning, staff must be oriented to the plan and understand their role in responding to a disaster or emergency situation (see Figure 1).

As the agency begins to formulate the plan, it will be helpful to remember that emergency planning for home care is a patient and family centered partnership that includes the patient and family or patient caregivers, agency and staff, the community, and local and state emergency planners and responders.



Figure 1

# Chapter 2

## **Michigan Emergency Preparedness**

The BETP is the emergency preparedness and response area within the Michigan Department of Health and Human Services (MDHHS). It serves to protect the health of Michigan citizens before, during and after an emergency through the integration of public health and medical preparedness initiatives and by leveraging diverse partnerships. The office maintains a dual role in both preparedness planning and in emergency response. These activities encompass all hazards, including natural and man-made disasters, acts of bioterrorism, infectious disease outbreaks and other emergencies that impact the health of the public.



Established in 2002 after the September 11<sup>th</sup> and anthrax attacks of 2001, BETP was created to coordinate both public health and medical preparedness and response activities within the state as needed.

As of July 1, 2012, the Public Health Emergency Preparedness (PHEP) and Hospital Preparedness Program (HPP) were federally aligned and funded exclusively through a single cooperative agreement with the U.S. Department of Health and Human Services. Program activities are guided by a national set of Public Health and Medical Preparedness Capabilities. In Michigan, the PHEP and the HPPs are integrated, working in concert to strengthen Michigan's preparedness and response capacity.

PHEP and HPP program activities are encompassed within several planning areas, some of which include medical surge planning, outreach and training. For information on specific PHEP and HPP initiatives that address specific planning areas, visit the <http://www.michigan.gov/BETP> homepage.

Predicated on the belief that strong partnerships are the golden thread woven throughout all preparedness achievements, BETP has established and continues to strengthen partnerships with other state, local, tribal and community stakeholders.

During public health emergencies, MDHHS becomes the lead agency in the response under the U.S. Department of Health and Human Service's Emergency Support [Function #8](#) (Health & Medical) of the National Response Framework. BETP maintains the Community Health Emergency Coordination Center (CHECC), which serves as the coordination center for MDHHS, working in direct collaboration with the State Emergency Operations Center. The CHECC provides real-time public health information relative to the incident, subject matter expertise, and coordinates the public health and healthcare response with local, regional and other state agency partners.

## *Regional Healthcare Coalitions*

Michigan established eight regional healthcare coalitions which are consistent with the eight emergency preparedness districts established by the Michigan State Police (MSP). These coalitions work with local partners within each region to prepare hospitals, emergency medical services, and supporting healthcare organizations to deliver coordinated and effective care to victims and survivors of public health/healthcare emergencies. Each region maintains one full-time regional coordinator, an assistant coordinator, and one part-time medical director. The leadership teams are employed or contracted through a Medical Control Authority (MCA). Visit the [website](#) for more information on the healthcare coalitions and how to become a partner agency and access valuable emergency preparedness resources.

## *Public Health Preparedness Planning*

Public health preparedness planning requires a solid understanding of the needs of citizens at a local level. It is through BETP's relationships with local health departments and tribal governments, and the Michigan State Police Emergency Management and Homeland Security Division that the office is able to support strategic and effective planning for all hazards across the State of Michigan. In addition, BETP partners with the Bureau of Disease Control, Prevention and Epidemiology, the Bureau of Laboratories, and federal agencies for surveillance, testing, and response to Michigan's health threats.

Through the Centers for Disease Control and Prevention's (CDC) PHEP cooperative agreement, Michigan's forty-five local health departments receive federal preparedness funding which supports an emergency preparedness coordinator (EPC). BETP works closely with each EPC to ensure all-hazards public health emergency planning. For more information on local health agencies visit <http://www.malph.org>.

The BETP partners with the Michigan State Police, Emergency Management and Homeland Security Division (MSP/EMHSD). Under the authority of the Michigan Emergency Management Act (MEMA), (public Act 390 of 1976, as amended). MSP/EMHSD is responsible for planning, mitigation, response and recovery from natural and human-made disasters within and outside the State of Michigan. This includes coordinating state and federal resources to assist local government in response and relief activities in the event of an emergency or disaster. The division is responsible to coordinate homeland security initiatives and implement federal preparedness and response grants. Through MEMA each county, some municipalities and some universities are required to appoint an emergency management coordinator.

Emergency management coordinators have responsibilities that include planning for hazard, risk identification, mitigation, preparedness, response and recovery in local jurisdictions.

**Because of the nature of the services home health care organizations provide, it is important that local emergency managers be made aware of each home care organization services and needs.** Information on county or municipal emergency management coordinators can be found by visiting the follow [link](#).

# Chapter 3

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## ***Elements of Planning***

The CMS has proposed specific conditions of participation related to emergency preparedness. The aim of this handbook is to help Michigan agencies meet the standards proposed or exceed them. More information on the proposed CMS guidelines can be found at this [link](#).

Regulations vary by state; while home care agencies are required to comply with CMS' overarching regulations, some states (i.e. New York) require home care agencies to follow additional state specific regulations for emergency preparedness. In Michigan, emergency preparedness is recommended but not regulated. Elements of the New York Department of Health's Home Care/Hospice Preparedness Guidelines can be found in [Appendix B](#).

## ***Critical Elements***

In the case of a Chemical, Biological, Radiation, Nuclear, or Explosive (CBRNE) incident or natural disaster, home care agencies must be able to rapidly identify patients at risk within the affected area. They should be able to call down their staff, have ready access to reliable incident specific information and be able to work collaboratively with their local emergency manager, local health department or other community partners. In order to accomplish these objectives, the following critical elements must be included in the home care agency's emergency preparedness plans:

- Identification of a 24/7 emergency contact telephone number and e-mail address of the emergency contact person and alternate;
- A call down list of agency staff and a procedure which addresses how the information will be kept current;
- A contact list of community partners, including the local emergency management, local health department, regional healthcare coalition, emergency medical services, law enforcement, utilities, durable medical equipment (DME) provider, and medical gas vendors. Including, a policy that addresses how this information will be kept current.
- Collaboration with the local emergency manager, local health department, regional healthcare coalition and other community partners in planning efforts, including a clear understanding of the agency's role and responsibilities in the county's comprehensive emergency management plan
- A current patient roster that is capable of facilitating rapid identification and location of patients at risk. It should contain, at a minimum:
  - Patient name, address and telephone number
  - Patient Classification Risk Level (see figure 2)
  - Identification of patients dependent on electricity to sustain life

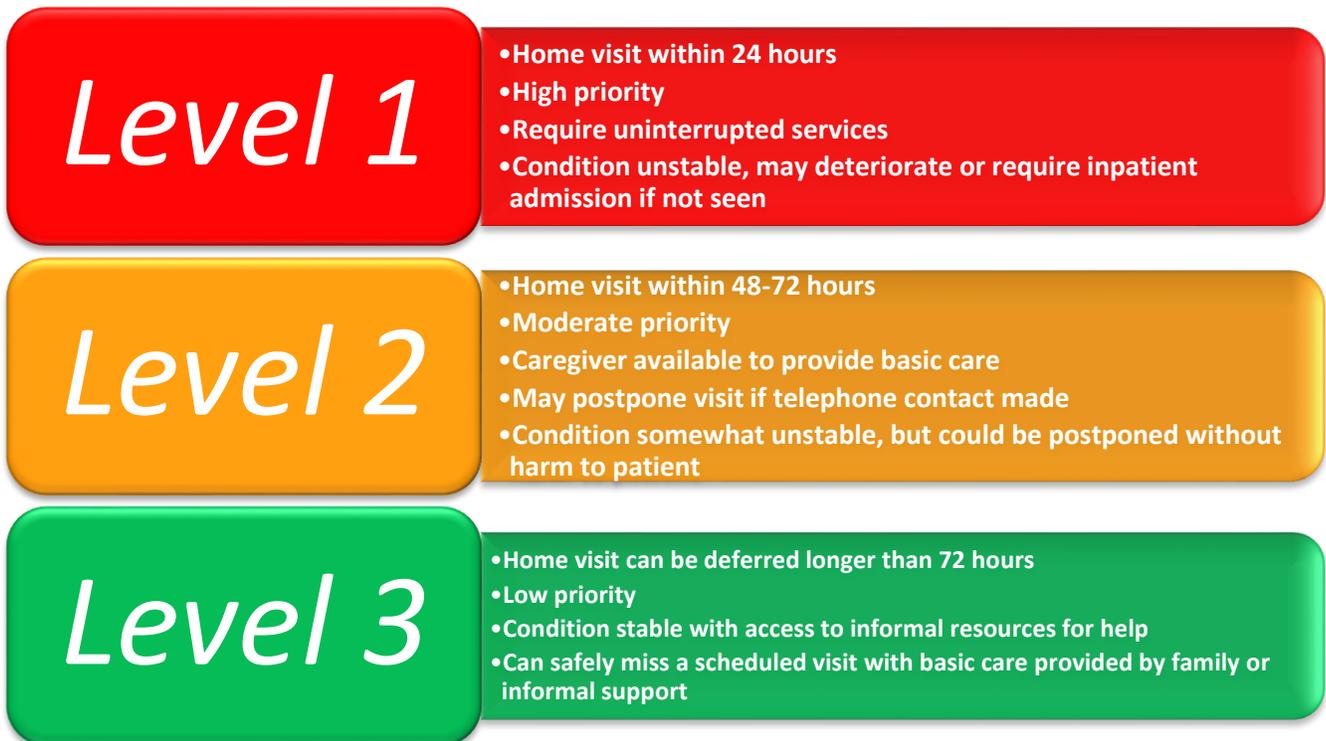
- Emergency contact telephone numbers of family/caregivers
- Other specific information that may be critical to first responders

- Procedures to respond to requests for information by the local health department, emergency management and other emergency responders in emergency situations;
- Policies addressing the annual review and update of the emergency plan and the orientation of staff to the plan;
- Records of participation in agency-specific or community-wide disaster drills and exercises.

### *Patient Classification Risk Levels*

The primary goal of emergency planning is an example of the provision of quality care while maximizing available resources. To support this goal information on an important patient classification system which could be used to satisfy patient roster identification requirements is noted below.

Under such a system, patients are, in effect, categorized for “triage” according to their need of services, (see figure 2) helping the agency determine how to stretch valuable staff and resources during an incident to ensure that the most vulnerable patients get the assistance they need. In addition, it allows for easy identification of high-risk patients to communicate needs to the local emergency manager.



**Figure 2**

These classifications levels are an important part of an emergency plan and should be included in the patient rosters maintained in accordance with the plan.

*Examples of the type of patient to classify at each level are:*

*Examples of level 1*

- No caregiver/support in the home or readily accessible support and cannot be left alone for extended period of time
- Bedbound; paralyzed; ventilator dependent; unable to meet physiologic & safety needs
- Daily insulin-dependent diabetic, unable to self-administer; not well regulated
- Fresh wound or extensive wound care, no support/assistance
- Infusion therapy requiring daily visits
- Apnea monitoring

*Examples of level 2*

- Uses assistive device – wheelchair, walker; able to manage alone for period of time up to 24-48 hours
- Equipment used as needed (PRN) – oxygen, suctioning, nebulization, patient controlled analgesia (PCA) pump
- Diabetic, self-administers insulin; requires skilled monitoring of blood glucose less than every 24 hours
- Extensive wound care, with support/backup assistance
- Cardiac / Respiratory with multiple medication changes in the past one-two weeks

*Examples of level 3*

- Able to manage alone for more than 72 hours; significant others or available support systems in place
- Mobile; independent functioning
- Uncomplicated routine wound care
- Self-manages medications/diet

*Pediatric Patients*

Pediatric patients receiving home health care are particularly at risk during an emergency. Often these patients are enrolled in the Children's Special Health Care Services (CSHCS) program due to serious or chronic health conditions. Due to the acuity and caregiver support needs, it is recommended that they be assigned as a risk level of 1 or 2. In addition, it is recommended that caregivers of CSHCS patients contact their local emergency manager and emergency medical services agency to provide awareness of their special medical needs and update them annually. Home health agencies should encourage this practice. Including but not limited to the identification of local resources to charge critical electricity dependent medical equipment.

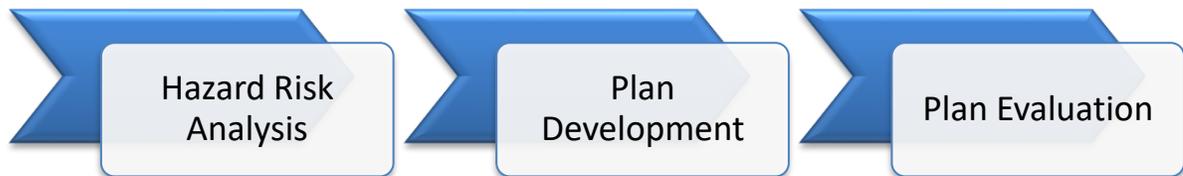
# Chapter 4

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## **Step 1: How Prepared is the Agency?**

The next step in emergency preparedness involves assessing the agency against regulations and best-practice benchmarks. Knowing, in advance, how an agency stacks up will make it easier to mitigate any possible gaps in the emergency plan.

For purposes of this handbook, there are three basic steps that can be followed in developing an emergency plan:



**Figure 3**

Step 1: Conducting a hazard/risk analysis and determining planning priorities

Step 2: Plan development and education

Step 3: Plan evaluation and plan updates

This handbook will provide guidance through the process of developing or updating the emergency preparedness plan in later chapters. The focus of this chapter, however, is the process of conducting a hazard analysis and determining planning priorities in advance of actually developing a plan.

As part of this first step, two important tools for self-assessment are identified: a hazard analysis worksheet and the Agency Preparedness Assessment and Planning Checklist (see Table 3).

### **Hazard Analysis Worksheet**

Home care agencies should work with local emergency management coordinators, local emergency management [directory](#), to understand potential local hazards.

Whether an agency is developing its first emergency plan, or updating an existing plan, it is important to understand both what the agency risks are and how prepared it is to respond successfully to any and all of those potential incidents. A separate analysis should be conducted for every agency office location, with differences being reflected in each location's plan. This hazard/vulnerability:

- Guides development/review of the emergency plan
- Identifies critical risks
- Factors the agency/community/patient perspective

- Allows one to customize the emergency plan based on appropriate levels of risk

To perform the analysis, providers should evaluate potential incidents (such as natural disaster, infectious disease outbreaks, man-made disasters and others) in each of various categories of probability, vulnerability and preparedness. Additional incidents can be included as necessary.

There are several issues to consider when determining the probability of risk. These include but are not limited to:

1. Known risk
2. Historical data
3. Manufacturer/vendor statistics

Issues to consider for vulnerability include but are not limited to:

1. Threat to life and/or health
2. Disruption of services
3. Damage/failure possibilities
4. Loss of community trust
5. Financial impact
6. Legal issues

Issues to consider for preparedness include but are not limited to:

1. Status of current plan
2. Training status
3. Insurance
4. Availability of backup systems
5. Community resources

To assist in this analysis, a Hazard Vulnerability Analysis Worksheet has been provided on the next page.

Instructions: Please review each potential incident in the worksheet (next page) and assign numbers evaluating

1. The probability of that incident happening (include the frequency and likelihood of the occurrence when assigning the number)
2. How disruptive that incident would be to the agency operations (consider how much impact to infrastructure damage, loss of life and service disruption)
3. How prepared an agency is (consider plan strengths and the organization's previous experience with the same or similar incidents). Then, multiply the three ratings for a total score (as shown in the example).

This worksheet will help prioritize and develop the plan based on the risks identified. For example, incidents that happen frequently, such as weather-related incidents, should be a priority in the plan. If the agency is near a nuclear power plant or a chemical plant, those are also most likely to be considered priorities in emergency planning efforts. Even risks such as cyber security and data safety need to be considered. The total values with the higher scores will represent the incidents most in need of organization focus and resources for emergency

planning. Note: The scale for preparedness is inverse to the order of probability and vulnerability.

**Hazard Vulnerability Analysis Worksheet (Table 1)**

All-Hazards										
Incident	Probability			Level of vulnerability/ Degree of disruption			Preparedness			Total Score
	High (3)	Mod (2)	Low (1)	High (3)	Mod (2)	Low (1)	Poor (3)	Fair (2)	Good (1)	
<i>Example</i>	3				2			2		$3 \times 2 \times 2 = 12$
Ice /snow										
Flooding										
Extreme Heat										
Earthquake										
Fire										
Hazardous Material Accident										
Tornado										
Nuclear/Radiation										
Civil Disturbance										
Mass Causality Incident										
Terrorist Attack										
Pandemic or Infectious disease										
Server Malfunction										
Cyber Attack										
Other										
Service Interruption										
Incident	Probability			Level of vulnerability/ Degree of disruption			Preparedness			Total Score
	High (3)	Mod (2)	Low (1)	High (3)	Mod (2)	Low (1)	Good (3)	Fair (2)	Poor (1)	
Electrical Failure										
Heating Failure										
Air Conditioning Failure										
Emergency Warning System Failure										
Communications Failure										
Information System Failure										
Water failure										
Transportation Interruption										
DME Interruption										
Other										

**Planning Priorities**

**Hazard Vulnerability Planning Priorities (Table 2)**

Review hazard analysis and level of vulnerability (based on responses in the worksheet on the previous page) and list top threats below.

	Hazard	Score
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

Add more if necessary:

The plan should address how each of the major threats will be addressed.

\*Note-There are other tools that can be used to assess hazards and vulnerabilities. This is a basic tool to get an agency started.

## **Agency Preparedness Assessment and Planning Checklist**

The Agency Preparedness Assessment and Planning Checklist is a framework for evaluating how complete the agency's plan is or should be. It may be modified to suit an agency's specific circumstances, but it is a good way to review the planning efforts.

This assessment can be conducted by looking at the agency's preparedness according to broad general categories, keeping in mind the need to support both continuity of care (patients) and continuity of operations (business).

These categories may be scaled to agency size and complexity and folded into an all-hazards plan based on each agency's level of risk. There are many parts that become "moving pieces" once a disaster hits. Those categories include:

- Administrative responsibilities
- Clinical care and documentation
- Patient plan and education
- Plan evaluation and update
- Surge capacity
- Patient safety
- Staff orientation, planning and training
- Transportation
- Supplies
- Utility considerations, including vehicle fuel
- Office integrity and patient record protection
- Finance
- Communication
- Community partnerships

If an agency has an existing plan, it should complete the Agency Preparedness Assessment and Planning Checklist to assess its overall readiness and then cross check with the hazard analysis form to update the overall level of risk (see [Table 3](#)). Once the risk areas are identified and prioritized, the agency can focus on preparing for specific targeted areas.

It's a good idea to review this list before the agencies plan is drafted, as it may help to organize the planning efforts.



(Table 3)

<b>Agency Preparedness Assessment and Planning Checklist</b>						
<b>ITEM</b>	<b>ITEM COMPLETED</b>	<b>REVISION DATE</b>	<b>PAGE NUMBER</b>	<b>NAME OR TITLE OF INDIVIDUAL(S) RESPONSIBLE</b>	<b>COMMENTS</b>	
<b>ADMINISTRATIVE</b>						
Emergency Response Committee or Team in place						
Business Continuity Plan in place for recovery phase including offsite access to data & data backup and office relocation (logistical support in place to relocate office if necessary)						
Incident Command System (ICS) – Emergency chain of command established. Pre-determined roles & lines of authority established with backup for each role						
Comprehensive Emergency Management Plan appropriate for “All-Hazards”						
Protocol for training of staff in Emergency Plan (EP), ICS, and roles in emergency situations						
Emergency contact/call down protocol in place for staff, with policies for updating contact information						
Equipment and supplies – plan for alternate vendor arrangements necessary						
Weekend/nighttime activation plan in place						
Emergency services resource plan (loss of power, water, gas, etc.)						
Employee orientation/job descriptions explain staff roles and responsibilities in emergency situations						
Surge Plan in place						
Annual Contact with Local Emergency Manager (LEM) about agency needs during an emergency						
Memorandums of Understanding (MOUs)						
<b>COMMUNITY PARTNERSHIPS</b>						
Plan for identifying and developing potential partner agencies/facilities, organizations, volunteers						
Contact with Local Emergency Management						

Partnership with Emergency Medical Services (EMS), Local Public Health & the health care delivery network in immediate/surrounding community is established					
Partnership established with Regional Healthcare Coalition (HCC)					
Community Partnership list updated					
Evacuation coordination current					
<b>POLICIES &amp; PROCEDURES</b>					
Protocols established to coordinate agency readiness with National Alert Levels					
Procedures in place to identify & review patient priority of care levels, including outstanding environmental risks or vulnerabilities					
Measures in place to respond to:					
1. Biological warfare or naturally occurring outbreak of disease					
2. Chemical emergency					
3. Nuclear or radiological emergency					
4. Mass trauma incident					
5. Weather related incident					
6. Transportation-related incident					
7. Power outage					
8. Isolation/Quarantine of patients; including mortalities					
9. Evacuation coordination with community; patient location					
Infection Control Plan developed & staff trained					
Personal protective equipment (PPE) plan & equipment policy and procedure in place					
Occupational Health – identified responsible person					

<b>SURVEILLANCE</b>					
Identify key clues that require investigation or activation of disaster plan					
Educate staff on syndromic surveillance and mandatory reporting procedures					
Maintain access to Michigan Health Alert Network (MIHAN)					
<b>RESPONSE</b>					
Definition of the circumstances (triggers) & responsible parties under which the Emergency Plan is activated					
Definition of the circumstances & responsible parties under which the Emergency Plan is stepped-down (deactivated)					
Ensure availability of patient data during power or computer failure					
Identify transportation alternatives/maps available					
Plan in place, if appropriate, for mass vaccination event					
Emergency supplies available for business continuity (7-10 days)					
Plan for decontamination/partners					
Plan for pet evacuation/placement					
Establish designated alternate/assembly point for staff					
System to track location of staff & patients in home health agency care during and after an emergency					
<b>PLAN EVALUATION</b>					
Community mock drill or facility-based mock drill conducted to test Emergency Plan (EP) in conjunction with local partners annually					
Paper-based, tabletop exercise annually					
After Action Report is created, reviewed and used to update plan					
Surge capacity contingency plan					
Staff acuity skill levels assessed & filed					

Patients prioritized by level of need of care					
MOUs with community partners					
<b>COMMUNICATION</b>					
Emergency Communications Center/Point of Contact (POC) Designated					
24/7 Communications Network with contingency plan if primary system disabled (cell phones, pagers, Radio Amateur Civil Emergency Service (RACES), satellite phones, wireless priority service, land phones)					
Electronic communication capability established with HCC and Bureau of EMS, Trauma and Preparedness (BETP) via internet (MIHAN)					
24-hour contact information for key Staff in a location that is accessible day and night					
Notification plan to ensure outside agencies/vendors are given notice					
Up-to-date contact information of key agencies, LEM offices, EMS, law enforcement, LHD, HCCs					
Physicians identified for telephone support with 24/7 contact information available					
Protocol for emergency mobilization of staff/call down & contact information					
Protocol to contact appropriate key outside agencies (LEM, LHD, HCC, etc.)					
Plan to communicate with patients and families re: services, counseling, updates & referrals					
Media/Risk Communication plan & responsible person, Public Information Officer (PIO)					
Policy for providing information about the general condition and location of patients cared for under 45CFR164.510(b)(4)					
<b>SECURITY</b>					
Plan for rapid identification of staff & emergency workers responding to a disaster					
Plan for handling security related to volunteers during an incident					
Plan for essential worker designation to ensure safe access to patients					

<b>EDUCATION</b>					
Orientation plan for new employees includes emergency preparedness expectations & training					
Plan for recurring education of staff defining roles/responsibilities					
All staff educated re: agency emergency plan annually					
Patient education – protocols developed for educating patients regarding agency emergency procedures; shelter in place; patient personal emergency plan on file					
Maintain documentation of training					
<b>EVACUATION</b>					
Patients registered with local utilities/Local Emergency Services					
Patients prioritized by shelter need/level of care					
Current shelter list maintained if available; contacts known					
Staff trained in evacuation procedures/alternate contact sites					
Patient transportation coordinated with community resources, if needed					
Communication link established with LEM					
Provisions for support services & counseling for patients, family and staff					
If volunteers are used, plan for prior recruiting, training, orienting, requesting and allocating during an emergency situation					
Plan for handling spontaneous volunteers during an emergency					
Plan for demobilization volunteers and providing for their mental health needs after the emergency					
<b>STAFF SAFETY</b>					
Staff trained in shelter-in-place & evacuation procedures					
Emergency Plan addresses the needs of staff, families and volunteers					

System in place for staff to verify the safety status of their family members in the community					
Staff have own emergency plan in place to ensure their availability and response during an emergency incident					
Staff immunization records					
PPE available; staff trained in safe work practices					
<b>BUSINESS CONTINUITY</b>					
Continuity of Operations Plan in place and updated					
Alternate Office/operations site identified					
Data backup available/remotely					

# Chapter 5

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## ***Step 2: Develop the Agency's Plan***

Once the initial steps are completed to assess the agency's risk areas, the next step is to begin the process of plan development. This section of the handbook is divided into a number of key categories that will help drive plan development. It should be noted, however, that these sections do not necessarily fall into a chronological order of development or a hierarchy of importance.

All major features of the emergency plan are of primary importance and, in many cases, can be prepared concurrently by the emergency preparedness planning team or committee, which should include a cross-section of staff roles, such as operations management, logistics, finance officers and clinical leadership.

If writing a new emergency management plan or improving a current plan, it is recommended to convene a representative task force to delegate policies and protocols related to each respective staff role. For example, within this group, have a member of the finance team lead the development of the continuity of operations policy; a member of the clinical team lead development of the policy on patient communications, education, and surge planning; or community outreach staff develops the policy for partnerships with other organizations.

At this stage, as staff are convened to discuss and delegate the elements of the emergency plan, it may also be a good occasion to also assign emergency management roles to these staff representatives, including the agency's incident commander, the individual responsible for dissemination of public information, the liaison officer and other logistical roles, as defined by state regulations and further detailed in the next section on required plan elements. This process would include establishing the hierarchy of the internal staff communications call-down list.

### ***Planning Assumptions***

Using information shared in this handbook as the basis for an emergency plan, the following points are valid assumptions in the emergency preparedness plan development:

- Plan is based on assessed risk and is the framework for agency response. Agency staff will be educated to function as described in the plan.
- Agency staff will educate and assist patients to the greatest extent possible.
- Agency staff will not be sent into hazardous areas or be required to operate under hazardous conditions during emergencies or disasters.
- Local and regional news media outlets will provide warnings and updates of natural and man-made emergencies. Government authorities may issue supplemental warnings.

- Agency personnel will have access to and pay attention to warnings and updates.
- The time needed to get a response from local emergency services will increase in proportion to the nature, severity, and magnitude of the incident.
- The agency will develop mutual aid or other agreements with other organizations as appropriate to ensure the care of evacuated patients.
- In a major emergency, hospitals may be able to admit only those patients who need immediate life-saving treatment. Hence, the hospital makes the final determination of which patients will be admitted or sheltered.
- In an emergency, the usual utilities and services could be unavailable for several days. Patients on life support devices requiring electricity should be registered with the local utility company supplying power to the patient's home and placed on a list held by the local emergency manager.
- The agency will educate and encourage, but cannot compel, patients or their families to follow a specific emergency plan. Patients have ultimate responsibility for planning appropriately. In the case of children, the parent or guardian has that responsibility.
- For their safety and to support continuity of agency operations, all staff will create their individual emergency plan and update it annually. This reminder can become part of an annual competency/performance evaluation.

Each of these basic themes is rooted in best-practice benchmarks and is again summarized below under several key categories.

### *Recommended Plan Elements*

Agencies should establish a written disaster plan that includes:

- A defined incident or disaster command team (disaster management team).
- Measures to respond to all possible incidents, including biological, chemical, nuclear/radiological, cyber-attacks and mass trauma incidents.
- Evidence of partnerships with local public health agencies, emergency medical services and the health care delivery network in the immediate or surrounding community. The agency should maintain a "phone book" or registry of all possible contacts, with individual names, roles, e-mails and phone numbers.

In the case of a CBRNE incident or natural disaster, home care and hospice providers must be able to rapidly identify patients at risk within the affected area. They should be able to call-down their staff, have ready access to reliable incident-specific information and be able to work collaboratively with their local emergency manager, local health department or other community partners. In order to accomplish these objectives, the following critical elements must be included in the provider's emergency preparedness plan:

- 24/7 Contact Information. The plan must include telephone numbers and e-mail addresses of the 24/7 emergency contact person as well as an alternate (a second alternate is recommended). It is recommended that everyone have a paper copy of these lists ([see Appendix C](#)).
- Call Down List. The plan must include an up-to-date call-down list or phone tree and policies and procedures to ensure its effectiveness, including who initiates calling, how calls are prioritized and how unanswered calls and callbacks are handled ([see Appendix D](#)).
- A Patient Roster that includes: patient contact information, the patient's priority level (i.e. Level 1, Level 2, Level 3); the ID of patients on life support equipment; family/caregivers' emergency contact numbers; and other specific information critical to first responders. It is also recommended that a patient roster also include: patients registered with local emergency services, if available; patients registered with the utility company; any shelter needs that have been identified; transportation assistance levels identification; a note that the patient and family have been educated about emergency preparedness at admission (this record should be updated every six months or with changes in patient's level of care); and a note that the patient has a "go" kit with all medical and contact information.
- Policies and Procedures to Respond to or Initiate Requests for Information or Resources. A sample policy would state:

During an emergency incident, all incoming and outgoing requests for information or help will be routed: through the agency's emergency communications center (555-1212; email@email.org) or through the office of the administrator. All requests for assistance or information must be approved by the incident commander (or administrator) prior to implementation. All incoming information will be relayed to: (.....) via (.....).

- There must be a policy defining the agency's 24-hour, 7-day-a-week coverage, or coverage consistent with the agency's hours of operation. It must be reviewed no less than once a year.
- Annual Policy Update and Staff Training: The plan must include an annual review and update of the emergency plan and a policy that addresses staff orientation to the plan and defines staff roles during an emergency. It is also recommended that plans include evidence of staff education targeted at employees' specific roles (paraprofessional, clinical, administrative, etc.)

### *External Operations*

Emergency plans should include:

- A Community Partner Contact List of local health department, local emergency management, emergency medical services and law enforcement and other partnering health organizations as well as a policy that addresses how this information will be kept current.
- Collaboration/ Planning with Partners. This section should show evidence of pre-

arrangements with community partners, including the agency's role and responsibilities in the city, town or county's emergency response plan, as well as a policy that ensures that the home care agency is an active participant in community emergency planning efforts, demonstrated by:

- A formal memorandum of understanding (MOU) or contract;
- Attendance at community emergency planning meetings which may include the Regional Healthcare Coalition;
- Basic knowledge of who's who in the community; and
- An outline or explanation of the agency's specific role and responsibilities during an emergency.

### *Drills and Exercises*

Policies should be maintained that address participation in agency-specific drills or community-wide drills and exercises. This can also include participation with exercises conducted by emergency management, public health and/or regional healthcare coordinators. As a best practice, it is also recommended that agencies include in their plans evidence which shows planning for and participation in drills and exercises, plus evaluation and plan updates resulting from after-action reports.

### *Gathering the Plan Elements*

What follows in the remainder of this chapter is an in-depth look at several categories (listed in alphabetical order) of items that should be factored into the agency's emergency plan.

These areas include further information about required elements of the emergency plan as well as best-practices.

Again, as the agency develops the emergency plan, it may be helpful to divide these areas of development up among the emergency planning committee. It is also recommended to consult the sample policies in [Appendix A](#) to find draft language.

### ***Business Continuity***

Business continuity or continuity of operations planning (COOP) is a vital part of agency preparedness and generally parallels the plan to continue patient care. Business continuity strategies focus on post incident business activities to ensure the agency is able to financially and operationally continue to provide services.

The business continuity plan may contain documents, instructions, and procedures that enable the agency to respond to accidents, disasters, emergencies and/or threats without any stoppage or delays in key operations. Planning generally extends to finance, logistics, human resources and information technology (IT).

Generally, business continuity implementation is one of the initial steps in the recovery process.

Once an emergency situation becomes stable, business recovery takes over to ensure the agency remains financially viable.

Examples of COOP planning include alternate office site identification, remote data backup, alternate communications, if phone service is affected, or billing and payroll capabilities if IT services are affected.

## **Communication**

Establishing effective communication within and outside the agency is one of the greatest challenges in emergency preparedness and requires both creative and redundant means of channel communication flow to everyone involved.

### *Internal*

Include a protocol to ensure that all relevant staff is rapidly notified in the event of a disaster. This requires 24-hour contact information to ensure the ability to rapidly contact staff to mobilize for duty. This communication plan should include:

- Agency Contact Information
- Plans for setting up an emergency communications center or point of contact
- A call-down list and alternate means of contacting staff (phone, e-mail, text blast, etc.)
- A patient communication plan

### *External*

Plan to ensure all outside agencies are notified. This requires the maintenance and distribution of an up-to-date list of all key agencies (EMS, local emergency management, local public health, Regional Healthcare Coalitions or other health care systems, etc). This communication plan should include contact information and protocols for:

- Local office of emergency management
- Local public health
- Regional Healthcare Coalition
- Community partner information and plans

## **MIHAN**

The Michigan Health Alert Network (MIHAN) is a secure web-based notification system created by the State of Michigan to alert key personnel of conditions that could adversely impact the health and safety of Michigan's citizens. The system also provides situational awareness about important but non-emergency health-related information.

MIHAN participants include key points of contact from the State of Michigan, local public health, hospitals, EMS agencies, Federally Qualified and Rural Health Clinics, Long Term Care facilities, and emergency management. Currently there are nearly 5000 MIHAN participants.

To register for a MIHAN account, go to the MIHAN website at <https://michiganhan.org> and click on the "Register Now" link at the bottom of the page. The account request has been reviewed and if approved, the registrant will begin to receive MIHAN alerts.

Each communication plan should clearly detail who is responsible for implementing each specific section of the communications plan. Patients, staff and community partners should know, in advance, what their agency's communications plan is as it relates to them.

**Communication Best Practices:**

- Determine what means of alternate communication is available during a power outage (e.g. hard-wired landlines, fax lines, website accessible from mobile phones, ham radio, etc.) and script out, if possible, the messages to be communicated;
- Keep a list of hard-wired and fax lines as well as cell phone numbers; and
- Be language savvy – identify language needs and literacy levels in advance, scripting out messages to make sure all pertinent information is included.

## ***Community Partnerships***

“All disasters are local” is a quote often used by emergency planners, and it is true that in seeking assistance outside of the agency, the first and best place to look is with traditional local public safety resources. Partnerships with others in the community can be a valuable resource and support.

It is imperative to establish collaboration with different types of healthcare providers (e.g. hospitals, nursing homes, hospices, home care, dialysis centers, etc.) at the state and local level to integrate plans of and activities of healthcare systems into state and local response plans to increase medical response capabilities.

It is important for all members of a community to meet and plan together to establish a joint response and clarify responsibilities. Like many health care providers, home care agencies are tied to other systems such as large hospitals or county health departments. However, their first responsibility is to serve their existing patients. Some planners make false assumptions about the availability of home care staff, so it is important to work with potential partners to make sure they fully understand the home care agencies abilities and limitations.

**Community Partnerships Best Practices:**

- Get Involved! Meet and network regularly with others that may be involved in community response plans. Keep a notebook of contact information and roles. In a disaster, it is easier to work with familiar people.
- If local authorities do not include the agency in planning efforts, reach out to them, document outreach efforts.
- Participate in the MIHAN.
- Participate in the Regional Healthcare Coalition.

## ***Demobilizing the Response***

One of the most overlooked parts of emergency planning is the process of demobilizing or “stepping down” and deactivating the plan and returning to normal. What is the transition plan? If patients are evacuated to shelters, for example, what is the process of returning patients home and resuming services? And who decides when the emergency is over, who oversees the deactivation, who gives the order?

The step-down process can reach deep into the agency’s operations and might include:

- Abbreviated paper assessments being converted to full electronic format;
- Contact with the local health department;
- Contact and collaboration with other providers, health care systems or community partners;
- Staff notification;
- Employee hours being updated in a system;
- Billing;
- Return to an office that was abandoned due to flooding or fire; and
- Reassessment of patient needs and possible return to original services.

The Agency Preparedness Assessment & Planning Checklist ([Appendix C](#)) provided earlier in this handbook is a detailed checklist to help assess whether or not agencies have covered all its bases when stepping down the agency’s response.

## ***Education***

### ***Patient Education***

Patient preparedness is a vital part of safe emergency response. Agencies should have policies related to patient and family or caregiver education, as well as policies outlining patient communication before, during and after the emergency.

The agency should be aware as to what family and community supports the patient has access to during an emergency incident. Likewise, the patient and/or family should know what to expect from the agency during a disaster.

There are many resources available online to assist with preparation for emergencies. It is recommended that patients all have “go-kits” containing easy-to-access information on emergency contacts, prescription medication needs, and supplies ([see Appendix E](#)). In reality, however, most patients will not have these at hand. Patients, should, however, be at least aware of the “must-dos” such as having a several-day supply of medications and a medication list. Patients should also be aware of the need to contact the agency if they decide to relocate prior to a pre-warned incident, such as a severe snowstorm, or if they change their plan from what was discussed with the agency.

Patients and staff can find planning tools and resources at the Michigan Prepares website: <http://www.michigan.gov/michiganprepares>.

#### Patient Education Best Practices:

- Review the patient's emergency plans at Start of Care, on a regular basis thereafter, and in advance of an event with pre-warning, such as flooding or snowstorm.
- Prepare a standard brochure or handout that outlines emergency procedures, patient responsibilities and expectations. Include agency contact numbers.
- Develop scripts for staff to use in patient communication before, during and after events to ensure patients receive the correct information in a uniform manner.
- Keep a file of downloads and handouts for events most likely to occur, ready to access as needed.

#### *Staff Education*

Staff education and preparedness are two of the most critical elements in emergency preparedness efforts. The availability and preparedness levels of the staff are vital to an agency's overall emergency response efforts.

Staff must be oriented to the plan and understand their role, how to respond and what their responsibilities are to the agency, the patients and to their own safety. Staff members must also understand that their role within the agency may change or shift, depending on the situation. For example, nurses that serve in administrative positions may have to re-enter field work.

Surveys show that while professional staff generally receive training, are oriented to the plan, and have made their own family plans, administrative staff and paraprofessional staff are far less prepared. Suggestions for training:

- Yearly emergency preparedness in-services are a good way to ensure agency paraprofessional staff is aware of policies, their role in a disaster, and the importance of having their own family plan.
- Seasonal events, such as Michigan Severe Weather Awareness Week (first full week of April) and Readiness Month (September) offer good opportunities to provide training.
- The American Red Cross offers extensive training in personal preparedness, and, in some cases, will do on-site training for home health agencies.
- Access regional healthcare coalition emergency preparedness trainings offered throughout the year.

#### Staff Education Best Practices:

- Include emergency preparedness in staff orientation programs, establishing it as part of their job responsibilities with the assurance they will not be asked to put themselves at risk as part of agency response;
- Hold regular briefings on seasonal threats, such as flooding, heat waves, or snowstorms;
- During staff education, incorporate basic lessons in ethics in emergency situations;
- Establish points of communication for staff via radio station, website, text message, etc., well in advance. Test their responses no less than once or twice a year.

## ***Evacuation and Mandatory Evacuation***

Agencies must plan to communicate and work with patients should an evacuation situation occur. It is critical that all patients and their families or caregivers are aware of what to expect during an emergency when services may be changed or discontinued, or when they may have to evacuate their places of residence (see Appendix F).

The agency/provider's goal is to maintain continuity of care, ensure patient and staff safety, and mitigate harm. In order to provide continuity of care during an evacuation or sheltering situation, agency staff, patients and their families must be aware of current events, options, transportation needs and shelter access information.

In Michigan, incidences that may result in the need for evacuation are most likely to occur due to wind damage, flooding, winter storms and there is a possibility of nuclear power plant incidents. Agencies should have a policy for evacuation incidents since these have occurred and may occur in the future. Policies must include:

- Staff education and definition of their role in evacuation situations; and
- Procedures to be taken if a patient refuses to evacuate.

The following are some procedural considerations if a patient refuses to evacuate:

- Assessment and documentation of the patient's understanding of the impact of their choice and the patient's assuming responsibilities for that choice;
- Variations of response based on the patient's priority status (a Level 1 patient may require a different response than Level 3);
- Notification to local authorities (fire department, emergency management, police, etc.) and
- Notification to Adult Protective Service.

It is important that patients understand the need to evacuate when a warning is given. If they procrastinate, it may become too late. It is also important for staff to understand their responsibilities during a mandated event and how to manage a situation where a patient refuses to evacuate.

### **“Safe and Well” Database**

The American Red Cross offers a [“Safe and Well”](#) searchable database to enable friends and family members to locate each other after a disaster.

### Evacuation and Mandatory Evacuation Best Practices:

The agency should have policies and procedures regarding:

- What information is conveyed to patients and their family/caregivers about emergency preparedness at admission and the frequency of review for long-term patients;
- When and how patients will be notified of an impending emergency/disaster, when known;
- The provision of communication in the language and level of health literacy appropriate to the patient;
- What measures the agency will take during mandatory evacuation or shelter-in-place situations, including coordination of transportation assistance;
- What a patient can reasonably expect if he or she refuses to evacuate when mandated, including loss of aide services; and
- A process for tracking patient location should evacuation occur.

Many agencies pre-identify patients' potential evacuation and transportation needs so they may be assisted more rapidly in the case of an actual incident.

### ***Immunizations***

Historically, preservation of the public health has been the primary responsibility of local and state governments, and the authority to enact laws relevant to the protection of the public health derives from the state's general police powers. With regard to communicable disease outbreaks, these powers may include the enactment of mandatory vaccination laws that extend existing immunization requirements for health care workers.

During the 2009 influenza A (H1N1) pandemic, despite an extensive public education campaign, less than half of health care workers were vaccinated against pandemic influenza. Michigan does not require immunization for healthcare providers. However, Michigan does require agencies to maintain records of immunizations and health records for all category A providers. For more information, refer to the Michigan Administrative code R 325.70015

Providers should have a system in place to ensure and document direct care staff immunization records, if required. Each agency should address how they would quickly immunize staff, should such measures be necessary.

### ***Infection Prevention and Control***

The agency's infection prevention and control plan should address issues related to rapid spread of disease from bioterrorism or natural causes such as pandemic influenza. The agency should have policies, procedures and/or MOU related to the rapid procurement of personal protective equipment. Agencies should have the ability to test or coordinate FIT testing for N95 masks or other personal protective equipment as needed. Agencies should work/contract with a local hospital in their fit testing efforts. All staff with patient care responsibilities should be trained on donning and wearing N95, including knowing how to "user seal check." User seal checks should be performed each time a mask is donned to ensure the respirator fits appropriately but it is not a substitute for FIT testing.

Beyond standard infection control training, professional staff should have basic training in syndromic surveillance and mandatory reporting.

Infection control in-services for paraprofessional staff should include information on infection control during emergency incidents, including outbreaks of infectious disease.

### ***Isolation and Quarantine***

While Isolation and Quarantine are not included in sheltering planning, it is possible that the agency will be affected by the quarantine or isolation of either the staff or patients. The CDC applies the term “quarantine” to more than just people <http://www.cdc.gov/quarantine>. It also refers to any situation in which a building, conveyance, cargo, or animal might be thought to have been exposed to a dangerous contagious disease agent and is closed off or kept apart from others to prevent disease spread.

The difference between isolation and quarantine can be summed up as follows:

- Isolation applies to persons who are known to be ill with a contagious disease.
- Quarantine applies to those who have been exposed to a contagious disease but who may or may not become ill.

#### ***Additional Definitions***

- Infectious disease: a disease caused by a microorganism and therefore potentially infinitely transferable to new individuals. An infectious disease may or may not be communicable. An example of a non-communicable disease is one caused by toxins from food poisoning or infection caused by toxins in the environment, such as tetanus.
- Communicable disease: an infectious disease that is contagious and which can be transmitted from one source to another by infectious bacteria or viral organisms.
- Contagious disease: a very communicable disease capable of spreading rapidly from one person to another by contact or close proximity.
- 

### ***Memorandums of Understanding***

#### ***Durable Medical Equipment***

Many home care agencies work with durable medical equipment (DME) vendors for the provision of critical patient supplies. Oxygen supplies are often limited during disasters. It is important that the agency has a memorandum of understanding with DME vendors to ensure the patients get the supplies they need. If DME is secured through a managed care organization (MCO), confer with the MCO or patient’s case manager in advance to establish the procedure for early delivery of critical medical supplies in advance of a known event, such as hurricane or blizzard.

#### ***Contractors – Staff***

To support staff numbers during a disaster, it is important to have MOUs with any and all vendors that supply staff or services, such as clinical, operational or administrative.

## *Mutual Aid*

Mutual Aid agreements are commonplace among health care providers and systems (see community partnerships) as a means of sharing.

## ***Mental Health***

### *Staff Support*

During and after an emergency incident, it is common for people—including response workers and health care staff—in the affected region to experience distress and anxiety about safety, health, and recovery, as well as grief and loss.

Most people are to some degree personally prepared for an emergency and have access to pre-existing support systems that contribute to their own and their community's resiliency, and thus they are likely to recover from disaster without behavioral health intervention. However, in an extended disaster, health care staff may be subjected to far greater stress both personally and professionally and become "secondary victims," as they work long, hard hours under poor conditions. Some will become "burned out" and be unable to perform their duties.

In some cases, physical dangers might exist in their travel to visit patients, adding to their levels of stress. Supervisors, administrative organization and regulation often change with little warning, adding confusion and additional stressors as workers try to satisfy the needs of the patients and of the agency.

Organizational response as a whole will depend, to some extent, on the extent to which staff feels that management is attempting to ensure their safety, minimize their stress and offer overall support.

In Michigan, mental health services are coordinated through local Community Mental Health Services Programs (CMHSPs). CMHSP contact information is found at this [link](#).

Disaster behavioral health resources may be found at this [link](#).

## ***Pediatric Patients***

### *Children's Special Health Care Services*

Pediatric patients receiving home health care are particularly at risk during an emergency. Often these patients are enrolled in the [Children's Special Health Care Services \(CSHCS\)](#) program due to serious or chronic health conditions. Due to the acuity and caregiver support needs, it is recommended that they be assigned as a risk level of 1 or 2. In addition, it is recommended that caregivers of CSHCS patients contact their local emergency manager and emergency medical services agency to provide awareness of their special medical needs and update them annually. Home health agencies should encourage this practice.

## **Resource Management**

Although home care agencies generally do not maintain extensive inventories, it is important to have a plan or structure in place to manage assets in supplies, including any vehicles, personal protective equipment, medical supplies, laptops, durable medical equipment and office supplies.

This may include supplies delivered to patients' homes and contracts with DME companies to supply oxygen and other critical resources.

## **Safety and Security**

The agency has an obligation to protect the security and safety of its staff. For example, staff should not be deployed just prior to the onset of a serious weather incident. Consider appointing a safety and security office to identify and take steps to mitigate factors that affect the safety of staff.

Planning for security may include developing policies and procedures for:

1. Working with local authorities to ensure staff has the appropriate identification and permissions to travel and access patients when conditions result in road or block closures;
2. Providing safe transport for staff when conditions warrant;
3. Facilitating rapid decontamination of staff;
4. Planning for safe evacuation of offices;
5. Locating all staff when a disaster is declared;
6. Providing appropriate personal protective equipment;
7. Providing winter "travel kits" for icy roads;
8. Ensuring staff understand the limits of their role in providing services during a disaster (not putting themselves in danger).

## **Sheltering**

It is important for agencies to understand what the different types of shelters are and where they might be located. The agency needs to provide accurate guidance to its patients and ensure their patients receive the care they need should they be housed in a shelter.

There are several types of shelters identified according to their population or purpose:

- General Population;
- Functional and Medical (formerly called "Special Needs");
- Pet/Animal;
- Temporary – warming or cooling; and
- Shelter-in-Place.

In Michigan, "mass" shelters are generally needed as a result of floods, snow or ice storms and extended power outages. Temporary warming and cooling shelters provide temporary respite, but they do not offer meals or sleep facilities. In the case of localized incidents such as fires that destroy housing units, often the American Red Cross will put displaced residents up in hotels rather than open a small shelter.

## *General Population Shelters*

Most General Population Shelters are operated by the American Red Cross and are often placed in schools. In some cases, local health departments or churches may open shelters. During an incident, local radio and or TV station should announce which shelters are open.

General population shelters may not accept pets (other than service animals) and may not provide medical care unless they are co-located with a Functional and Medical Needs Shelter. It is important for caregivers to accompany patients to shelters to provide the level of assistance that is required at home. Open shelters may be searched by zip code on the American Red Cross [website](#). It is advised that this website be kept handy. Information is updated every 30 minutes.

## *Medical, Functional and/or Special Needs*

Medical Shelters may be opened by local authorities to take care of a population that needs medical, medication or Activities of Daily Living (ADL) support but does not require hospital care. Many home care patients fit into this category. Each county or municipality may implement sheltering with a different approach depending on their resources and the scale of the incident. As a provider, the administrator should speak with local emergency management officials about the process for medical, functional or special needs shelter and understand what the agency's role is in sheltering. In addition, the agency patients must be made aware of what they should take with them to the shelter, including any assistive technologies, medications, special dietary food, etc.

Locations of Functional and Medical Needs Shelters should be available from the local emergency manager's office, or on the county or municipality's website.

Patients should plan to have their own family or aide accompany them if they need assistance with activities of daily living (ADL).

## *Pet Shelters*

Local jurisdictional pet sheltering plans vary by locations. These shelters are usually run by local pet protection agencies under contract with the local authority. Information should be current, so on a regular basis contact the local authorities to find out what arrangements are available for the patient's pets. Shelters require pet owners to bring pet food, medications, and in some cases, health records.

## *Warming and Cooling Shelters*

When power outages occur during periods of extreme heat or cold, municipalities may open heating or cooling shelters. These shelters are only a temporary respite and do not offer the services that General Population shelters do.

## *Shelter-in-Place*

In certain circumstances – for example, when there is an incident such as a dirty bomb or unexpected gas release – it may be safer for patients and/or their staff to remain indoors. At other times, incidents might restrict evacuation or egress, forcing individuals to remain at home. Although most shelter-in-place situations are really a matter of hours, it is important for both staff and patients to be aware of the possibility of extended shelter in place and be prepared, within reason, to spend at least three days at home (see Appendix F).

Local officials are the best source of information when determining whether to evacuate or shelter-in-place. In general, sheltering-in-place is appropriate when conditions require that people seek immediate protection in their home, place of employment, school or other location when disaster strikes.

Shelter in place specifically means selecting an interior room or rooms within the home, or ones with few or no windows, and taking refuge there. These locations should be identified within the organizations physical structure and within a client's home. It is very important to follow the instructions of local authorities which may be issued via television or radio regarding sheltering-in-place. These locations should be identified within the organizations physical structure and within a client's home.

Items for consideration, based on the situation:

- To go or to stay?
- Warning/alerting staff
- Knowledge of possible health threats, immediate safety and counter measures
- Communication with patients
- Staff and family readiness
- Staff and patient education
- Patient preparedness, including food and medication
- Office preparedness (how long can staff stay?)

Resources include:

The United States Department of Labor Occupational Safety & Health Administration (OSHA)  
<http://www.osha.gov/SLTC/etools/evacuation/shelterinplace.html>

The American Red Cross  
<http://www.redcross.org/www-files/Documents/pdf/Preparedness/shelterinplace.pdf>

FEMA  
<http://www.fema.gov>

MI Prepares  
<http://www.michigan.gov/michiganprepares>

#### Sheltering Best Practices:

- Identify, in advance, which patients and staff live in nuclear power plant evacuation zones
- Understand the sheltering process and educate patients as to their nearest evacuation center.
- Identify the safest physical location to shelter in place.

### ***Surge Plan***

During a large-scale incident, hospitals may need to discharge large numbers of patients due to an expected increase in admissions. In some cases, facilities or other providers may need to “relocate” their patients as a result of evacuations.

Home care is frequently viewed as a sound discharge plan for those patients being prematurely discharged.

Agencies should have policies and procedures related to:

- The ability to assess their current surge capacity at any given time, including their ability to manage patients on a continuing basis;
- Safely discharging and/or stepping down patient services as needed, using the patient risk assessment tool, to accommodate additional needs or respond to barriers to service created by an emergency;
- The use of an abbreviated admission form to facilitate rapid admission. (An example of an OASIS C Abbreviated assessment form is available at <http://www.homecareprepare.org>);
- Identifying current staff skills, capabilities and numbers, including administrative staff that may be able to take on a clinical role if necessary; and
- Working with community partners to pool resources, including staff.

It is important for all home care agencies to work with inpatient facilities within their service area to identify and communicate what mechanisms can be expected should hospitals initiate their immediate bed availability (IBA) plans. Activation of plans may cause a surge in the request for home care services.

### ***Transportation Plan***

Home care agency services require access to transportation. The agency plan should include alternate transportation sources and plans for transit strikes, weather-related road closures and other incidents that may impede staff providing patient care. Staff should be trained in agency expectations and supports during an incident that might impact travel.

### ***Mi Drive***

Michigan Department of Transportation offers the [Mi Drive website](#) where users can see updated information on construction & traffic, lane closures, traffic incidents, and weather reports by city or zip code.

## NIXLE Alerts

[NIXLE CONNECT](#) allows public safety agencies to connect with residents and community agencies via text, web, and email with important notifications. These alerts go beyond emergency response and provide information related to community outreach, public relations and emergency mitigation.

## Waivers

### Transportation Best Practices:

- Outreach to local county or municipality regarding home care workers' being regarded as essential workers during emergency situations.
- Policies and procedures or MOUs for fuel procurement.

During an emergency incident, it may be necessary for regulatory bodies to issue waivers to health care providers to temporarily streamline the process and ensure patients have access to care. These waivers are time limited but allow providers more flexibility in the way they provide services.

It is important to understand that federal waivers, generally extend, but do not eliminate, deadlines.

### Definition of an 1135 Waiver

When the President declares a disaster or emergency under the Stafford Act or National Emergencies Act and the U.S. Department of Health and Human Services (HHS) Secretary declares a public health emergency under Section 319 of the Public Health Service Act, the Secretary is authorized to take certain actions in addition to the Secretary's regular authorities. For example, under section 1135 of the Social Security Act, the Secretary may temporarily waive or modify certain Medicare, Medicaid, and Children's Health Insurance Program (CHIP) requirements to ensure that sufficient health care items and services are available to meet the needs of individuals enrolled in Social Security Act programs in the emergency area and time periods and that providers who provide such services in good faith can be reimbursed and exempted from sanctions (absent any determination of fraud or abuse). Examples of these 1135 waivers or modifications include:

- Conditions of participation or other certification requirements
- Program participation and similar requirements
- Preapproval requirements
- Stark self-referral sanctions
- Requirements that physicians and other health care professionals be licensed in the State in which they are providing services, so long as they have equivalent licensing in another State (this waiver is for purposes of Medicare, Medicaid, and CHIP reimbursement only – State law governs whether a non-federal provider is authorized to provide services in the State without state licensure)
- Performance deadlines and timetables may be adjusted (but not waived)

- Limitations on payment for health care items and services furnished to Medicare Advantage enrollees by non-network providers

These waivers under section 1135 of the Social Security Act typically end no later than the termination of the emergency period, or 60 days from the date the waiver or modification is first published unless HHS extends the waiver by notice for additional periods of up to 60 days, up to the end of the emergency period.

Waivers Best Practice:

- Identify potential needed waivers (such as aide supervision) in advance and assign responsibility to an individual for coordinating waiver needs and tracking issuance during an incident. The abbreviated OASIS assessment, for example, can ONLY be used when an 1135 waiver is in effect

# Chapter 6

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## ***Step 3: Test and Evaluate the Agency's Plan***

Emergency drills and exercises are a central part of the preparedness stage of the crisis planning cycle and should be utilized to evaluate not only the plan, but to familiarize staff with the plan and their expected response.

When faced with an emergency, people respond as they have trained – which is why firefighters and other emergency responders frequently participate in emergency drills and exercises.

Exercises should be conducted to evaluate the capability to execute one or more portions of an Agency Preparedness Assessment and Planning Checklist. Exercises should be carefully planned to achieve one or more identified goals.

These exercises:

- Test and evaluate the plan, policies, and procedures.
- Reveal any weaknesses that may be in the plan and identify any resource gaps that may be present.
- Improve individual performance, organizational communication, and coordination.
- Train personnel and clarify roles and responsibilities.
- Satisfy regulatory requirements.

An effective exercise program is made up of progressively complex exercises, each one building on the previous, until the exercises are as close to reality as possible. When possible, the exercise program should involve a wide range of organizations to support the agency's role in community response.

Remember: the plan is never complete. Writing the plan is only the beginning of preparedness. Testing it, looking for gaps and amending it are a critical and ongoing component of the emergency planning efforts.

### ***“Paper” Review***

Things change, often more quickly than realized. The agency should review its plan for accuracy – places, people, numbers, current policies, etc. – at a minimum of once a year, with communication information being updated more frequently. A call-down tree, or communication strategy, should be updated at least monthly.

### ***Learning from Real Incidents***

Many agencies use “real incidents” to fulfill their drill or exercise requirements. While this is certainly understandable, it is important to use lessons learned from those incidents to review and update the existing emergency plan. “Hot washes” or reviews while the emergency is winding down should be translated into after-action reports (AARs) and improvement plans that

pinpoint areas the agency needs to work on to more successfully respond to future incidents. Once the AAR is completed, its conclusions can provide valuable insight into needed plan updates.

### *All-Hazards Drills and Exercises*

There are different levels of drills and exercises. It is recommended that agencies develop a multi-year plan to assess their response capability in a comprehensive manner. Agencies will often use specific drills to test different parts of their plan and then fold those components into a larger, more complex exercise.

- Orientation Seminar – This is a low-stress, informal discussion in a group setting with little or no simulation. The orientation seminar is used to provide information and introduce people to the policies, plans and procedures in the organization’s Comprehensive Emergency Management Plan.
- Drill – This is the exercise organizations are most familiar with. The drill is a coordinated, supervised exercise used to test a single specific operation or function. Call downs are the most commonly used drill in home care.
- Tabletop Exercise – a facilitated group analysis of an emergency situation in an informal, stress-free environment. The tabletop is designed for examination of operational plans, problem identification, and in-depth problem solving.
- Hybrid Tabletop/Functional – This model is used in situations where it is not practical to do a completely functional exercise. For example, the emergency operations center and communications systems might be fully functional in a hurricane drill, but patient evacuation might be “on paper.”
- Functional Exercise – The functional exercise is a fully simulated interactive exercise that tests the capability of an organization to respond to a simulated event. This exercise focuses on the coordination of multiple functions or organizations and takes place in an Emergency Operations Center. The Functional Exercise strives for realism, short of actual deployment of equipment and personnel.
- Full-Scale Exercise – The full-scale exercise is a simulated emergency event, as close to reality as possible. It involves all emergency response functions and requires full deployment of equipment and personnel.

### ***After Action Report and Improvement Plan***

FEMA offers the following explanation of an After-Action Report:

The After-Action Report/Improvement Plan (AAR/IP) aligns exercise objectives with preparedness doctrine to include the National Preparedness Goal and related frameworks and guidance.

Exercise information required for preparedness reporting and trend analysis is included in the AAR/IP template provided in [Appendix G](#); users are encouraged to add additional sections as needed to support their own organization needs.

#### Test and Evaluation Best Practice Recommendations:

- Appoint a committee to analyze the agency's vulnerabilities and build a progressive exercise and evaluation plan.
- While it's "handy" to have a real incident to document for regulatory or accreditation requirements, it might be wise to use a tabletop to explore the agencies readiness for other incidents.
- Reach out to community partners to leverage participation in their drills.
- All incidents or planned events should have an AAR and improvement plan.

## **Additional Resources**

CDC Emergency Response Resources:

<http://www.cdc.gov/niosh/topics/emres/business.html>

National Association for Home Care & Hospice website:

<http://www.nahc.org>

Home Care Prepare website:

<http://www.homecareprepare.org>

Homeland Security Exercise and Evaluation Program:

<https://www.fema.gov/media-library/assets/documents/32326>

Hospital Preparedness Exercises Atlas of Resources and Tools (2010)

<http://archive.ahrq.gov/prep/hospatlas/hospatlas.pdf>

CDC Identifying Vulnerable Older Adults and Legal Options for Increasing Their Protection During All-Hazards Emergency

<http://www.cdc.gov/aging/emergency/pdf/guide.pdf>

Individuals with Disabilities or Access & Functional Needs

<http://www.ready.gov/individuals-access-functional-needs>

Michigan State Police Emergency Management & Homeland Security

<http://www.michigan.gov/msp/0,4643,7-123-60152---,00.html>

MI Prepares

<http://www.michigan.gov/michiganprepares>

MI TRAIN a learning resource site for professionals who protect the public's health

<https://mi.train.org/DesktopShell.aspx>

IS 100.b Introduction to Incident Command System

IS- 200.b ICS for Single Resources and Initial Action Incidents

IS- 700.a National Incident Management System (NIMS) An Introduction

IS- 800.b National Response Framework, An Introduction

IS-139 Exercise Design

<http://training.fema.gov/IS/crslist.aspx>

These and many more helpful tools can be found on the Home Health Care Disaster Planning Resources page at the <http://www.michigan.gov/BETP> website.

## **(Appendix A)**

### **Sample Emergency Preparedness Policy Language**

NOTE: The policy language contained in this Appendix is not comprehensive. The model language in this appendix is provided to assist providers in crafting their own individualized plans. We strongly recommend agencies check their policies and procedures against those required by CMS, or any other regulatory agency, to ensure its emergency plans meet regulations. These sample policies may be used as a basis for developing agency-specific policies in each of the covered areas.

#### **All-Hazard Emergency Preparedness Policy and Goals**

##### *Sample Language:*

This plan uses the term “all hazard” to address all types of incidents. An incident is an occurrence, caused by either humans or a natural phenomenon, which requires or may require action by home care and emergency service personnel to prevent or minimize loss of life or damage to property and/or the environment.

Examples of incidents include:

- Fire, both structural and wildfire
- Weather related emergencies including snow, ice storms, heat and flooding
- Hazardous materials accidents
- Technology failures
- Cyber attacks
- Power outages
- Transit and worker strikes
- Natural disasters
- Terrorist/WMD incidents.
- Incidents of naturally occurring disease outbreak
- Planned Public Events, such as political conventions, sports events

The goal of this plan is to allow smooth transition of patient services, ensure continuity of care for all patients served by this agency, provide for the safety and security of staff and maintain continuity of business operations during an emergency.

##### Objectives

- To identify the chain of command /Incident Command System
- To identify primary and alternative command centers
- To allow for the timely identification of the patients who are affected in the case of an emergency.
- To provide those patients with the care and assistance that they need in the event of an emergency
- To be readily available to assist emergency responder personnel in first aid care for those in the community
- To assess patient’s home environment for safety and assist them to a safe environment if needed

- To coordinate Agency staff members in patient care and evaluation, as well as any Agency personnel assistance with care of those in the community who are affected by the emergency
- To identify staff roles and responsibilities

*Plan Deactivation*

*Sample Language:*

The Director, who serves as the Incident Commander, has the authority to activate and deactivate this Emergency Preparedness Plan based on information known to her/him at the time, which indicates such need. If the Director is not available, the Assistant Director, and then the Charge Nurse, will have the authority to activate/deactivate the response plan.

*Sample Organizational Chart for Plan Activation*



## Sample Assignment Sheet for Plan Activation

Assign roles by person or by organizational role.

Position	Examples of Organizational Role	Responsibilities	Assigned to
Incident Commander (IC)	Administrator	<ol style="list-style-type: none"> <li>1. Establish/maintain overall response strategy and coordination</li> <li>2. Policy level decision making</li> </ol>	
Command Staff <ol style="list-style-type: none"> <li>1. Information Officer</li> <li>2. Liaison Officer</li> <li>3. Safety and Security</li> </ol>		<ol style="list-style-type: none"> <li>1. Central Point for Information dissemination, media coordination</li> <li>2. Point of Contact for other agencies</li> <li>3. Ensures best practices for safety coordination.</li> </ol>	
Operations	VP Operations	Directs all incident response activities	
Planning & Intelligence	Deputy Administrator	Collects, analyzes key information Formulates Incident Action Plan; Maintains documents, prepares for demobilization Document tracking and retention.	
Logistics	Human Resources, facilities department	Responsible for acquisition and maintenance of facilities, staff, equipment, materials	
Finance/Administration	Controller	Monitors costs, contracts, financial and time reporting	

### *Incident Command Center*

#### *Sample Language:*

Unless the emergency renders the agency office unusable, the Incident Command Center will be located at the main office ( ... address). The alternative site will be at the branch office (... address).

Both offices will maintain data backup through remote data servers, hard wired phones, and emergency generators.

### *Planning – Administration*

#### *Sample Language*

- Each office will keep and maintain a current list of contact information for staff, staff family members, vendors, emergency services, hospitals and other appropriate community resources. Said list should include phone numbers, alternate phone numbers, emails and text capabilities.
- The agency director will ensure the existence of an incident command system and/or comparable emergency response team to respond to an emergency situation.
- The agency will participate in and document evidence in community planning efforts.
- All staff shall receive emergency preparedness training appropriate for their position during orientation and on a yearly basis, at a minimum.
- All staff will receive guidance and education on establishing their own personal and family response plan.

### ***Patient Care and Planning***

#### *Sample Language:*

- On admission, the admitting nurse will assign each patient a priority code, dictating that patient's emergency rating. The admitting nurse will obtain a list of contact numbers and discuss emergency planning options with the patient and family. All information will be kept in the patient's chart and shall be kept in paper as well as electronic format. At that time, each patient will be given a planning checklist, resource materials, and a list of items to have prepared and available for use in the event of an emergency.
- Any patients requiring power for life support equipment will be registered with the local utility companies and with local emergency offices. Each patient and family will receive education that will assist them in managing emergencies.
- A list of vendors who supply each patient's medical supplies will be obtained and kept in the patient's chart.

### *Plan Activation – Emergency Call Down Procedure*

#### *Sample Language:*

Once the emergency response plan is activated, the Director will notify the Assistant Director and Office Manager to initiate the staff call down procedure.

- The Office Manager will notify (            ), and then each will notify persons listed below them on the calling list. If they are unable to reach an employee on the telephone, they will proceed to the next listed person on the list. The Office Manager or their designee will call the office, identify the available employees, and then come to the office. Upon arrival, every five (5) minutes, Office Manager will try those employees who could not be reached with the first call attempt and notify the Disaster Supervisor(s) of any other employees found to be available on standby. They will also manage calls upon arrival at the office. If Office Manager is not able to reach the Secretary, Office Manager will notify all persons on the calling list.
- If phones are not available, the information officer will contact two (2) prearranged radio stations (Wxxx; Wxxx) with an announcement for staff and patients. Additional efforts to contact staff will be made by email, text blast.
- The (    ) will have power to assign staff to specific tasks, and with the coordinator will work with appointed Team Leaders to assist in pinpointing patients affected by the emergency and assigning clinical staff members to check on those patients by utilizing the pre- arranged priority classification system. (see last page).
- After the Office Manager/designee has called and put a staff member on alert, that staff member will wait for an Emergency Supervisor to call back with their assignment and where to meet their partner or security escort, if assigned.

### *Security*

#### *Sample Language:*

The Security Officer's role is to ensure the safety of staff and patients and support the security of agency operations.

- The Security Officer will make assessments regarding the security of the command center, the safety and travel conditions for staff and make arrangements for relocation of the command center, transportation and/or safety escorts as needed.
- The Security Officer will also ensure all staff has needed identifying badges and/or uniforms which will allow them access to their agency.
- The Security Officer will work with agency leadership and local/county officials to ensure safe passage and access to patient homes when roads are closed.

### *Internal Communications*

#### *Sample Language:*

The agency will maintain an updated contact list of all staff, which will ... (supplied to all

supervisory personnel, posted on the agency internal intranet, etc.).

During an emergency incident, all incoming and outgoing requests for information or help will be routed (e.g.):

- through the communications center or
- through the office of the administrator

All requests must be approved by the incident commander (or administrator) prior to implementation.

### *External Communications and Emergency Communications Center*

- The agency will maintain an active MIHAN Account and identify sufficient coordinators to ensure ready access and information flow to and from the agency during an emergency situation
- The agency will keep an up to date communications directory in both electronic and hard copy that lists all potential needed response partners, including but not limited to health care, local, state and federal government, emergency services and local resources
- The agency will subscribe to local emergency notification services (specify)
- The agency will designate an emergency communications center (ECC) and/or point of contact through which all communications flow.

### *Public Information*

#### *Sample Language:*

- The Public Information Officer (PIO) will confer with the Incident Command Officer and other members of the Disaster Response Team to reach a joint decision regarding the information, if any, to be released to the media. The PIO will also be in charge of determining alternate means of contacting staff.

### *After Receiving Notification of an Emergency: Direct Care Staff*

#### *Sample Language:*

- Do not leave home until receiving an assignment.
- When an emergency call and assignment is given, all of the available information about the emergency and those affected will be provided. Do not ask questions when called. This will only slow down the rate of calling and response time to the emergency.
- Please wear the agency nametag and shirt so agency staff can be easily recognized by other cooperating agencies.
- A second emergency call may come through so limit use of agency phone.
- If phone lines are down listen to radio stations (xxxx; xxxx) for instructions.
- If there is no power, or phone lines, open the emergency kit provided by the agency which includes a battery-operated radio, and bus/subway tokens which will enable staff to go to the prearranged meeting area if staff do not have their own transportation.

### *When an Emergency Occurs After Work Hours: Direct-care Staff*

#### *Sample Language*

- Call the Agency office to let the Emergency Supervisors know your availability to help. You may receive an assignment at that time.
- If there are no working telephones, either go to the triage site or to the Agency office (whichever is closest) for an assignment.

### *When an Emergency Occurs During Working Hours: Direct Care Staff*

#### *Sample Language:*

- When reporting for an assignment, a decision will be made by one of the Emergency Supervisors which staff 1) will help with emergency assessments, or 2) be assigned to continue with regular assignments, or 3) to assume patients left from those staff assigned to work on the emergency assessments. Staff members who have had first aid training are considered high priority for emergency assessment assignments.

### *Emergency Assessments*

#### *Sample Language:*

- Each nurse or aide making home visits to patients must check in with the Agency office with an update (frequency). Any new assignments will be made at that time. When the nurse has completed the list of patients assigned to them, they will be assigned to a community assistance first aid site to help with triage if needed or will be assigned to specific patients from the regular case load to complete that day's schedule. At least one (1) Emergency Supervisor will be present at the designated check in site to further assign Agency employees as they arrive and coordinate the staff members. If a patient needs to be moved to another site, the following procedure will be followed:
- If the patient is unharmed but the home is damaged or unsafe and the telephone system is working, contact family or friends that the patient may request and make arrangements for the patient's transportation. Keep track of where the patient is going and all necessary telephone numbers or contact the Emergency Supervisor for arrangements to be made through the county emergency planners for transportation to an alternate care facility if other arrangements cannot be made.
- If the patient is injured and needs transport, contact an Emergency Supervisor for arrangements to be made through the county emergency planners for transport to a hospital/emergency room/triage site, depending on the need as determined by the county emergency planners. Be sure to have a complete list of the patient's needs when notifying the Emergency Supervisor.

Remember: The official personnel who are at the site (police, ambulance personnel, etc.) have had training in handling emergencies, as well as potentially hazardous situations. If told not to go to a certain area, don't go. In the event of damaged, blocked or impassable roads, staff

members will take alternate routes or notify an Emergency Supervisor of inability to reach an area.

1. Unsafe Home Situation
2. Before entering a patient's home, determine if there is a safety issue (possible gas leak, exposed electric wire, etc.). Assess the situation and report to an Emergency Supervisor, who will report to the county emergency planners for proper emergency personnel to secure that site.

### ***Emergency Supply Storage Area***

*Sample Language:*

An emergency supplies storage area will be maintained at the Agency office for employees during the time period that they are working in the event of an emergency and will be updated and maintained by the (assigned).

Each month, all Emergency Supervisors will get an updated copy of the emergency list and keep it at home for reference if an emergency occurs after hours, or if the Agency office is damaged or destroyed. When Director gets a call asking for assistance with an emergency, she will call Assistant Director and Office Manager. Both will then go to the Agency office immediately. Immediate tasks for the Emergency Supervisors will be:

- Determine the area struck and those patients of the Agency that are affected by the emergency.
- The priority classification for each of these patients.
- An assignment list.
- While this is being determined, calls will be made to nursing homes and residential care facilities to determine the number of rooms which will be available for temporary placement of displaced patients and to local authorities to determine shelter options and locations. The Emergency Supervisors will also maintain a list of employees who have been notified and are available to assist in the emergency assessments. The patients who need assessments will be reassigned among the staff available and an Emergency Supervisor will then call each employee with assignments for who their team member is as well as the patient assignments.
- Calls will be made for prearranged transportation of patients in need of evacuation.

### ***Emergency During Working Hours***

*Sample Language:*

- When the Director gets a call asking for assistance with a disaster, she will notify Assistant Director, as well as the Office Manager and Secretary to begin the calling chain. Director and Assistant Director will determine the patient and staff assignments and keep a list of those staff members the callers have been able to contact, as well as a list of those patients each nurse has yet to see, so that any necessary redistribution of the patient assignments can be made.
- Office Staff will report to an Emergency Supervisor on those staff members that they have been able to contact, as well as which patients each of those nurses has yet to see. The Emergency Supervisors will in turn determine the assignments for those patients affected by the disaster. The teams will be notified of their assignments and the current patient

caseload will also be assigned to the staff. Teams will need to meet their partner(s) at one of the three sites listed below:

1. If the phone system is working and the disaster is local meet at the Agency and receive disaster supplies packet from one of the Emergency Supervisors.
  2. If there is no phone system and the disaster is local, meet at the pre-designated triage site and receive disaster supplies packet from one of the Emergency Supervisors.
  3. If the disaster is at another town, meet at the pre-designated triage site and receive disaster supplies packet from one of the Emergency Supervisors or at an assigned location.
- The emergency supply packet will consist of various supplies that may be needed, as well as emergency worksheets.
  - An Emergency Supervisor will then go to the triage site to coordinate any patient needs that may exist, for problem solving and coordination of our efforts with the Emergency Response personnel and the county emergency planners. If the phone system is working, Director or Assistant Director will remain at the office to manage information and coordinate calls from staff, family members, etc. If the phone system is not working, Director will also go to the triage site and Assistant Director will remain at the office to sign out other emergency supply packets and assist any staff members who may arrive.
  - Each emergency assessment team will fill out the emergency worksheet and turn them in to the Emergency Supervisors at least hourly with a report on the condition of patients that they have assessed during that time frame. This emergency worksheet helps the Emergency Supervisor(s) to maintain a tracking list for identification of those patients assessed, their status and what location they were moved to, if necessary.
  - If assistance is requested by local authorities, those Emergency Supervisors who are at the triage site will coordinate Agency staff assignments for this. If our assistance is not requested, we will meet at the Agency office for a debriefing, allowing all involved to express their feelings, as well as ideas to improve for the next emergency plan implementation.

### ***Drills and Exercises***

#### *Sample Language:*

The agency will

- Review the emergency plan no less than annually (paper review);
- Conduct evaluation drills or exercises; and
- Update the plan based on results of those evaluations.

Agency staff members will participate in a minimum of one drill or exercise to determine the effectiveness and efficiency of the current policy and any forms developed for use in a disaster.

### ***Plan Deactivation: Call-Down Procedure***

#### *Sample Language:*

Once the emergency response plan is de-activated by the ( ), the Director will notify the Assistant Director and Office Manager to initiate the staff call down procedure and step

down procedure to normal operations.

The ( ) will provide critical personnel an operational plan for the return to normal operations, including but not limited to:

- Staff notification
- Patient notification/possible location
- Patient Reassessment for services
- Documentation completion
- Damage reports
- Inventory
- Community Communication protocols
- Evaluation of agency performance

## **(Appendix B)**

### *NY Department of Health's Home Care/Hospice Preparedness Guidelines*

- *Establish an active, functional disaster response committee or team with an incident command (management system). The team should: consist of relevant members who can add specific expertise to each type of disaster event. Nursing, professional medical staff, allied health care providers, infection control, as well as key administrative staff, are vital to the overall plan.*
- *Ensure the agency has a written disaster plan that would include: a defined Incident or Disaster Command Team (disaster management team); and measures to respond to biological, chemical, nuclear/radiological and mass trauma events. In addition, the agency must work in partnership with local county health units and county Emergency Medical Services and the health care delivery network in the immediate or surrounding community to develop the disaster plan for both internal and external disasters.*
- *Define predetermined roles, lines of authority, and chain of command and communication. Alternates/backup for each role should also be assigned.*
- *Establish a protocol for the education of staff regarding the disaster response plan, including the role of the staff.*
- *Establish a 24/7 communications network with alternate communications systems identified, if the original network becomes disabled.*
- *Identify and plan for activation of the response plan if night-time or weekend activation is required.*
- *Establish a protocol for contacting staff, emergency resources and/or outside agencies in the event of a disaster.*
- *Maintain up-to-date contact lists of staff and key agency contacts such as local health unit, local emergency management team (shelter identification), local law enforcement and Regional, New York State Department of Health staff.*
- *Develop a system to rapidly notify and disseminate information to staff (telephone trees, broadcast fax, e-mail, community bulletin boards, etc.).*
- *Include disaster preparedness drills or exercises to test the efficacy of the plan in conjunction with the local partners included in the plan.*

*The overall plan should focus on the following elements:*

*Surveillance  
Response  
Communications Security  
Education*

#### *Surveillance*

- *Identify key diagnostic clues that may activate further investigation or activation of the disaster plan.*
- *Ensure all staff is educated on the surveillance indicators, the chain of command, the reporting protocol and the legal responsibility to report.*

#### *Response*

- *Define the circumstances under which the plan is activated and terminated.*

- *Develop or enhance a protocol for mobilizing the necessary emergency workers, staff and possible volunteers.*
- *Establish a designated assembly point for staff to report (if alternate site is needed).*
- *Ensure the availability of agency site basic emergency disaster supplies and equipment [i.e. generators, batteries, blankets, person protective equipment (PPE), water source, emergency documentation packets, tracking of staff, recall listings, service area maps, etc.].*
- *Ensure that essential patient specific information is available that provides patient prioritization and information that is pertinent in the continuance of ongoing medical care, as well as family contact information.*
- *Identify transportation alternatives (i.e. mass transit unavailable for staff use, the use of local law enforcement, the use of personal vehicles).*
- *Consider the use of service area maps for staff to geographically provide services (coinciding with their residential location to lessen travel).*
- *Ensure the availability of potential additional equipment needs, PPE and supplies for off-site staff (required for each event).*
- *Ensure the education of all staff on appropriate infection control precautions for each type of event and the proper use of the personal protective equipment.*
- *Establish a plan for patient prioritization for response and/or evacuation, environmental decontamination in conjunction with community partners that includes the area, facility or portable device to be used, a protocol for the decontamination and who is responsible to perform the function.*
- *Develop a system for the identification, tracking, admission and discharge of mass casualties/victims.*
- *Develop a contingency plan when reaching surge capacity for admissions in partnership with the local emergency management agency, county health departments, emergency management services and other health care delivery systems. The plan should describe methods to increase admission capacity, facilitate rapid transfers and/or discharges, the implementation of diversion plans and identifying additional staffing.*
- *Determine needs for specialized equipment and supplies (ventilators, personal protective equipment, and pharmaceuticals) based on each type of event and current inventory. The plan should include methods to access additional supplies if needed.*
- *Develop protocols for placement of patient, type of precautions and or isolation (if required) and other infection control measures for each type of event and a plan to educate staff.*
- *Develop a plan for the safe handling, storage, tracking and preparation of bodies post mortem. This may include arrangements with the county and emergency management agency or other health care delivery systems partners to appropriate sites, space and/or additional supplies and resources needed for infection control purposes.*
- *Establish contacts for pet placement/evacuation.*

### Communications

- *The 24-hour, 7 day-per-week communication network should include internal and external components.*
- *Internal communications: A notification protocol to ensure that all relevant agency staff is rapidly notified in the event of a disaster. This requires 24-hour contact information for all key staff, including home telephone, pagers, cell phones and electronic mail as well as a telephone tree system or emergency notification software to ensure the ability to rapidly contact staff to mobilize for duty.*
- *External communications: Notification plans to ensure all outside agencies are notified. This requires the maintenance and distribution of an updated list of all key agencies [i.e. New*

## Home Health Emergency Preparedness

*York City Department of Health, if applicable, the New York State Department of Health (regional), local emergency management services and City /County Emergency Management Office].*

- *Provision of staff support/debriefings ongoing throughout all phases of the disaster plan.*
- *Ensure the disaster plan addresses the communication to families with provision of support services, counseling, information updates and referrals.*

### *Security*

- *Develop or enhance a plan for rapid identification of staff and emergency workers responding to a disaster.*
- *Consider a plan for the pre-hospital triage/decontamination for routing potentially contaminated victims to the appropriate areas prior to entering the hospital.*

### *Education*

- *Develop disaster education tools and plan for all staff members defining roles and responsibilities.*
- *Develop educational tools defining specific biological/chemical/nuclear exposure symptoms, care and specific PPE for each.*
- *Ongoing exercise/drill of disaster plan.*

**(Appendix C)**

**Agency Emergency Contact List**

Agency Name	Primary Phone Number	Secondary Phone Number	Primary Point of Contact	Secondary Point of Contact	Email
<b>Emergency Medical Services</b>					
<b>Law Enforcement</b>					
<b>Fire</b>					
<b>Local Emergency Manager</b>					
<b>Electric Company</b>					
<b>Gas Company</b>					
<b>Local Public Health Department</b>					
<b>Regional Healthcare Coalition</b>					
<b>Hospital(s)</b>					
<b>Vendors</b>					
<b>Durable Medical Equipment</b>					
<b>Other</b>					



**(Appendix E)**

**Patient Emergency Preparedness Plan**

<b>Emergency Contact Information</b>			
<b>Role/Relationship</b>	<b>Name</b>	<b>Phone</b>	<b>Address</b>
<b>Primary Emergency Contact Person</b>			
<b>Out-of-State Contact</b>			
<b>Call 911 for Emergencies</b>			
<b>Non-Emergency Local Police</b>			
<b>Local Red Cross</b>			
<b>Local Emergency Management Office</b>			
<b>Primary Care Physician</b>			
<b>Pharmacy</b>			
<b>Medical Equipment Supply Company</b>			
<b>Neighbor</b>			
<b>Relative</b>			
<b>24/7 info about critical health and human services available in the community</b>	2-1-1 Call Center	Dial 211 for free from any phone	N/A
<b>Poison Control</b>		1-800-222-1222	

Patient Medical Information				
<b>Name</b>			<b>Date of Birth</b>	
(i.e. Jack Doe)			(i.e. 05/05/1947)	
Doctors				
Name of Doctor	Specialty	Last Appointment	Next Appointment	Phone Number
(i.e. Dr. Jane Smith)	(i.e. Cardiac)	(i.e. April 3, 2014)	(i.e. August 5, 2014 1pm)	(i.e. 517-555-4555)
Allergies/Sensitivities				
<b>Allergy</b>			<b>Type of Reaction</b>	
(Drug Name)			(i.e. Hives)	
Medications				
Name	Route	Dose	Frequency	
(i.e. Lasix)	(i.e. oral)	(i.e. 20mg 1 tablet)	(i.e. daily)	
Medical History				
<b>Medical Condition</b>		<b>Date Diagnosed</b>	<b>Ongoing or Resolved</b>	
(i.e. Congestive Heart Failure)		(i.e. May 2005)	(i.e. Ongoing)	
Surgeries		Date of Surgery		
(i.e. Right Total Knee Replacement)		(i.e. April 2004)		

Insurance Information			
Type of Insurance	Company	Policy Number	Phone
Health			
Prescription			
Homeowners/Rental			
Auto			

**Personal Preferences**

(Please list any personal care preferences)

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**Meeting Places**

Neighborhood meeting place: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

Outside of neighborhood meeting place: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

In case providers are separated from household members in an emergency, the American Red Cross "Safe and Well" website allows people to list themselves as "safe and well" or search for others who have registered. The site is available at <https://safeandwell.communityos.org>.

### Basic Emergency Supplies

- Household Emergency Plan
- First Aid Kit
- Water (one gallon per person per day for at least three days)
- Shelf-Stable Foods (no cooking/refrigeration required)
- Manual Can Opener
- Weather Radio
- Flashlight
- Solar Power or Hand Crank Charger
- Extra Batteries
- N-95 Respirators
- Moist Towelettes
- Large Garbage Bags
- Wrench or Pliers to turn off utilities

Additional Items (fill in any additional items staff may need)

- Item 1:
- Item 2:
- Item 3:
- Item 4:
- Item 5:
- Item 6:
- Item 7:
- Item 8:
- Item 9:
- Item 10:

Bigger Purchases to Consider

- Cell Phone Air Card for Internet Service
- Generator

## Emergency Supply Checklist

In addition to the basic survival supplies, a preparedness kit should contain items to meet individual needs in various emergencies. Consider items used on a daily basis and which ones that may be needed to add to the agencies kit.

- A weeklong supply of prescription medicines
- Extra eyeglasses
- Hearing-aid batteries
- Extra wheelchair batteries
- Oxygen
- Pet food, extra water, collar with ID tag, medical records and other supplies for service animal
- A watertight container for important documents
- List of all medications with dosages
- List of allergies
- List of the style and serial number of medical devices
- Special instructions for operating assistance or medical equipment
- Copies of medical insurance and Medicare cards
- Wills
- Power of attorney documents
- Deeds
- Bank information
- Tax Records
- Cash or travelers' checks
- Contact information for doctors, relatives, and friends
- Create a support network. Keep a contact list in a watertight container in the preparedness kit.
- Identify back-up service providers for any routine or life-sustaining treatments administered by a clinic or hospital
- Know the size and weight of your wheelchair, in addition to whether or not it is collapsible, in case it has to be transported.
- Prepare medical equipment in your home that requires electricity for use during a power outage.
- Wear medical alert tags or bracelets
- Know what special assistance you may need during an emergency or if you are forced to leave your home
- Provide trusted individuals with a key to your home
- Inform trusted individuals where you keep your emergency supplies
- Show trusted individuals how to use lifesaving equipment and/or administer medicine
- If you have a communication-related disability, note the best way to communicate with you
- Setup to receive you benefit payments electronically to avoid disruptions in mail service

The Treasury Department requires federal benefit payments to be made electronically. You can choose to get your payments by direct deposit to a bank or credit union account or to a **Direct Express®** Debit MasterCard® card account. Sign up by contacting the U.S. Treasury Electronic Payment Solution Center at (800) 333-1795. You may also sign up for direct deposit online or at your local bank or credit union.

The Direct Express® prepaid debit card is designed as a safe and easy alternative to paper checks. Call toll-free at (877) 212- 9991 or sign up online.

**(APPENDIX F)**

**EVACUATION GUIDELINES**

<b>ALWAYS:</b>	<b>IF TIME PERMITS:</b>
<b>Keep a full tank of gas in your car if an evacuation seems likely. Gas stations may be closed during emergencies and unable to pump gas during power outages. Plan to take one car per family to reduce congestion and delay.</b>	Gather your disaster supply kit.
<b>Make transportation arrangements with friends or local government if you do not own a car</b>	Wear sturdy shoes and clothing that provides some protection, such as long pants, long sleeved shirts, and a cap.
<b>Listen to a battery-powered radio and follow local evacuation instructions.</b>	Secure your home: <ul style="list-style-type: none"> <li>• Close and lock doors and windows</li> <li>• Unplug electrical equipment, such as radios and televisions, and small appliances such as toasters and microwaves. Leave freezers and refrigerators plugged in unless there is a risk for flooding.</li> </ul>
<b>Gather your family and go if you are instructed to evacuate immediately.</b>	Let others know where you are going.
<b>Leave early enough to avoid being trapped by severe weather.</b>	
<b>Follow recommended evacuation routes. Do not take shortcuts; they may be blocked.</b>	
<b>Be alert for washed-out roads and bridges. Do not drive into flood areas.</b>	
<b>Stay away from downed power lines.</b>	

Source: Are You Ready? *Basic Preparedness*. FEMA. from [http://www.fema.gov/pdf/areyouready/basic\\_preparedness.pdf](http://www.fema.gov/pdf/areyouready/basic_preparedness.pdf)

**(APPENDIX G)**

# **[Exercise Name]**

After-Action Report/Improvement Plan

[Date]

The After-Action Report/Improvement Plan (AAR/IP) aligns exercise objectives with preparedness doctrine to include the National Preparedness Goal and related frameworks and guidance. Exercise information required for preparedness reporting and trend analysis is included; users are encouraged to add additional sections as needed to support their own organizational needs.

## Exercise Overview

<b>Exercise Name</b>	[Insert the formal name of exercise, which should match the name in the document header]
<b>Exercise Dates</b>	[Indicate the start and end dates of the exercise]
<b>Scope</b>	This exercise is a [exercise type], planned for [exercise duration] at [exercise location]. Exercise play is limited to [exercise parameters].
<b>Mission Area(s)</b>	[Prevention, Protection, Mitigation, Response, and/or Recovery]
<b>Core Capabilities</b>	[List the core capabilities being exercised]
<b>Objectives</b>	[List exercise objectives]
<b>Threat or Hazard</b>	[List the threat or hazard (e.g. natural/hurricane, technological/radiological release)]
<b>Scenario</b>	[Insert a brief overview of the exercise scenario, including scenario impacts (2-3 sentences)]
<b>Sponsor</b>	[Insert the name of the sponsor organization, as well as any grant programs being utilized, if applicable]
<b>Participating Organizations</b>	[Insert a brief summary of the total number of participants and participation level (i.e., Federal, State, local, Tribal, non-governmental organizations (NGOs), and/or international agencies). Consider including the full list of participating agencies in Appendix B. Delete Appendix B if not required.]
<b>Point of Contact</b>	[Insert the name, title, agency, address, phone number, and email address of the primary exercise POC (e.g., exercise director or exercise sponsor)]

## Analysis of Core Capabilities

Aligning exercise objectives and core capabilities provides a consistent taxonomy for evaluation that transcends individual exercises to support preparedness reporting and trend analysis. Table 1 includes the exercise objectives, aligned core capabilities, and performance ratings for each core capability as observed during the exercise and determined by the evaluation team.

Objective	Core Capability	Performed without Challenges (P)	Performed with Some Challenges (S)	Performed with Major Challenges (M)	Unable to be Performed (U)
[Objective 1]	[Core capability]				
	[Core capability]				
[Objective 2]	[Core capability]				
[Objective 3]	[Core capability]				
<p><b>Ratings Definitions:</b></p> <ul style="list-style-type: none"> <li>• Performed without Challenges (P): The targets and critical tasks associated with the core capability were completed in a manner that achieved the objective(s) and did not negatively impact the performance of other activities. Performance of this activity did not contribute to additional health and/or safety risks for the public or for emergency workers, and it was conducted in accordance with applicable plans, policies, procedures, regulations, and laws.</li> <li>• Performed with Some Challenges (S): The targets and critical tasks associated with the core capability were completed in a manner that achieved the objective(s) and did not negatively impact the performance of other activities. Performance of this activity did not contribute to additional health and/or safety risks for the public or for emergency workers, and it was conducted in accordance with applicable plans, policies, procedures, regulations, and laws. However, opportunities to enhance effectiveness and/or efficiency were identified.</li> <li>• Performed with Major Challenges (M): The targets and critical tasks associated with the core capability were completed in a manner that achieved the objective(s), but some or all of the following were observed: demonstrated performance had a negative impact on the performance of other activities; contributed to additional health and/or safety risks for the public or for emergency workers; and/or was not conducted in accordance with applicable plans, policies, procedures, regulations, and laws.</li> <li>• Unable to be Performed (U): The targets and critical tasks associated with the core capability were not performed in a manner that achieved the objective(s).</li> </ul>					

**Table 1. Summary of Core Capability Performance**

The following sections provide an overview of the performance related to each exercise objective and associated core capability, highlighting strengths and areas for improvement.

## [Objective 1]

The strengths and areas for improvement for each core capability aligned to this objective are described in this section.

## [Core Capability 1]

### Strengths

The [full or partial] capability level can be attributed to the following strengths:

Strength 1: [Observation statement]

Strength 2: [Observation statement]

Strength 3: [Observation statement]

### Areas for Improvement

The following areas require improvement to achieve the full capability level:

Area for Improvement 1: [Observation statement. This should clearly state the problem or gap; it should not include a recommendation or corrective action, as those will be documented in the Improvement Plan.]

Reference: [List any relevant plans, policies, procedures, regulations, or laws.]

Analysis: [Provide a root cause analysis or summary of why the full capability level was not achieved.]

Area for Improvement 2: [Observation statement]

Reference: [List any relevant plans, policies, procedures, regulations, or laws.]

Analysis: [Provide a root cause analysis or summary of why the full capability level was not achieved.]

## [Core Capability 2]

### Strengths

The [full or partial] capability level can be attributed to the following strengths:

Strength 1: [Observation statement]

Strength 2: [Observation statement]

Strength 3: [Observation statement]

### Areas for Improvement

The following areas require improvement to achieve the full capability level:

Area for Improvement 1: [Observation statement. This should clearly state the problem

or gap; it should not include a recommendation or corrective action, as those will be documented in the Improvement Plan.]

**Reference:** [List any relevant plans, policies, procedures, regulations, or laws.]

**Analysis:** [Provide a root cause analysis or summary of why the full capability level was not achieved.]

### Appendix A: Improvement Plan

This IP has been developed specifically for [Organization or Jurisdiction] as a result of [Exercise Name] conducted on [date of exercise].

Core Capability	Issue/Area for Improvement	Corrective Action	Capability Element <sup>1</sup>	Primary Responsible Organization	Organization POC	Start Date	Completion Date
Core Capability 1: [Capability Name]	1. [Area for Improvement]	[Corrective Action 1]					
		[Corrective Action 2]					
		[Corrective Action 3]					
	2. [Area for Improvement]	[Corrective Action 1]					
		[Corrective Action 2]					

<sup>1</sup> Capability Elements are: Planning, Organization, Equipment, Training, or Exercise.

## Appendix B: Exercise Participants

Participating Organizations	
<b>Federal</b>	
<b>State</b>	
<b>[Jurisdiction A]</b>	
<b>[Jurisdiction B]</b>	